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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, in his official capacity as United States Attorney General, *et al.*,

Petitioners,

v.

State of OREGON, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals For the Ninth Circuit

AMICI CURIAE BRIEF OF 52 RELIGIOUS AND RELIGIOUS FREEDOM ORGANIZATIONS AND LEADERS IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICI*

This *amici curiae* brief is being filed on behalf of a diverse array of religious organizations, leaders, and scholars as well as advocates of religious liberty. *See* Appendix of *Amici Curiae*, attached. These organizations and leaders represent a variety of religious and spiritual faiths and their congregations that support an individual's freedom to choose physician-assisted dying as a moral and honorable means of ending one's life with dignity and grace. The *amici* therefore support Oregon's enactment of the Death With Dignity Act as a means of honoring and respecting each individual's freedom of religion and conscience in making this most deeply personal and sacred of choices.[1]

STATEMENT

1. Eight years ago in *Washington v. Glucksberg*, 521 U.S. 702 (1997), and *Vacco v. Quill*, 521 U.S. 793 (1997), this Court was asked to decide if, within the bounds of the Due Process Clause of the Fourteenth Amendment, a state has the power to decide whether or not to criminalize physician assistance to patients wishing to hasten their own impending deaths. This Court decided that the states do have such authority, emphasizing that the legitimacy of physician-assisted dying is far from a settled issue and that the national discussion and debate about how best to protect the dignity and independence of those who are terminally ill should continue. This Court therefore held that the individual states were free to make their own policy choices regarding this deeply personal, intimate, and important issue. *Glucksberg*, 521 U.S. at 735-36. As the Court concluded in *Glucksberg*, "[t]hroughout the Nation, Americans are engaged in an

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[1] Pursuant to Supreme Court Rule 37.6, no person other than counsel identified on the cover participated in authoring this brief. No entities other than *amici* and counsel provided financial support for this brief. Furthermore, the consent of the parties to the filing of this *amici curiae* brief has been obtained and filed with the Clerk of the Court.

earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." 521 U.S. at 735.

Concurring, Justice O'Connor explained:

> As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, "the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . in the first instance."

Id. at 737 (O'Connor, J., concurring) (citations omitted).

2. On November 7, 1997, less than five months after the Court issued its decision in *Glucksberg*, the citizens of Oregon reaffirmed the Oregon Death with Dignity Act ("ODWDA" or "the Act") by decisively voting down a proposal to repeal the law. Originally enacted in 1994, the ODWDA establishes tightly controlled procedures under which competent, terminally ill adults under the care of an attending physician may obtain a prescription for Schedule II controlled substances in sufficient kind and quantity to allow them to control the time, place, and manner of their deaths. Or. Rev. Stat. § 127.805. The attending physician must determine, among other things, the patient's mental competence, Oregon residence, diagnosis, and prognosis, and the diagnosis and prognosis must be confirmed by a second physician. *Id.* §§ 127.800(8), 127.815. Only patients suffering from a "terminal illness," defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months," may be given such prescriptions. *Id.* § 127.800(12). The physician must then ensure that the patient understands his or her diagnosis and prognosis, the risks and probable results of taking the prescribed medication, and the alternatives to hastening his or her impending death, including, but not limited to, hospice care and pain relief. *Id.* § 127.800(7). Once a request from a

qualifying patient has been properly documented and witnessed, and all waiting periods have expired, the attending physician may prescribe, but not administer, medication that would enable the patient to end his or her life in a humane and dignified manner. *Id.* §§ 127.840, 127.850-.855, 127.880. The ODWDA immunizes physicians and pharmacists who act in compliance with its comprehensive procedures from civil or criminal sanctions, or professional disciplinary actions based on that conduct. *Id.* § 127.890.

3. In response to requests by members of Congress in late 1997, including then-Senator John Ashcroft, Attorney General Reno investigated the question of whether practitioners acting in accordance with the ODWDA could be subject to federal prosecution under the Controlled Substances Act ("CSA"). On June 5, 1998, Attorney General Reno issued a letter confirming that physician-assisted dying lies well outside the bounds of the CSA:

> The Department has reviewed the issue thoroughly and has concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA. . . . There is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice.

Letter from Janet Reno, Attorney General of the United States, to Henry J. Hyde, Chairman, Committee on the Judiciary, U.S. House of Representatives (June 5, 1998).

Three years later, however, Attorney General Ashcroft attempted to offset the CSA's silence on the issue by announcing his own policy, in the form of a "directive." *See* Pet. App. 100a, 104a. Relying in part on *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001), in which the Court found that no "medical necessity" exception was required by federal law or equity to the CSA's listing of marijuana as a substance with no currently confirmed medical benefits, Attorney General Ashcroft determined that

the CSA allows him to decide unilaterally that physician-assisted dying is not a "legitimate medical practice" under the CSA, thereby effectively overriding the ODWDA. Therefore, contrary to the position taken three years earlier by then-Attorney General Reno, the Ashcroft Directive threatens federal action against physicians and pharmacists acting under the ODWDA. *See* Pet. App. 100a-105a.

4. Upon the request of the State of Oregon, physicians and terminally ill patients, the U.S. District Court for the District of Oregon immediately entered a temporary restraining order against the Ashcroft Directive on November 8, 2001, and later permanently enjoined the Attorney General from giving any legal effect to the Ashcroft Directive, concluding that "Congress did not intend the CSA to override a state's decisions concerning what constitutes legitimate medical practice." *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1084 (D. Or. 2002). The Ninth Circuit agreed, holding that the Ashcroft Directive "violates the plain language of the CSA, contravenes Congress' express legislative intent, and oversteps the bounds of the Attorney General's statutory authority." *Oregon v. Ashcroft*, 368 F.3d 1118, 1120 (9th Cir. 2004). The court of appeals thus continued the district court's injunction in full force and effect as its own. *Id.* at 1131. This Court has now granted certiorari to review the case.

SUMMARY OF ARGUMENT

Consistent with *Glucksberg* and the system of federalism outlined there, the ODWDA protects the spiritual interests of Oregon's terminally ill by allowing them, in certain limited situations, to control the timing and circumstances of their deaths. By unilaterally denying the legitimacy of physician-assisted dying as sanctioned by the people of Oregon, the Attorney General exceeded his statutory authority, and did nothing more than impose his unilateral moral and policy views on the people of Oregon.

The decision to choose physician-assisted dying is inevitably and deeply connected to an individual's personal

beliefs and concerns not only about bodily integrity, dignity, and autonomy, but also about the greater religious and spiritual implications of death and how one lives one's last moments. Accordingly, the decision to seek help in ending one's life is one that necessarily entails an individual's freedom of religion and conscience. Some faiths, religious organizations, and religious leaders steadfastly oppose physician-assisted dying, but that is by no means the universal view. Numerous faiths, religious organizations, and religious leaders strongly support physician-assisted dying as an entirely legitimate and moral choice by which the terminally ill can hasten their impending deaths with dignity and integrity.

For this and other reasons, this Court in *Washington v. Glucksberg* and *Vacco v. Quill* suggested that the heavily policy-laden choices regarding the morality and legality of physician-assisted dying should be left to the "laboratory" of the individual states. 521 U.S. at 737 (O'Connor, J., concurring). The states should be permitted not only to experiment with various approaches to the issue but also to honor the varying religious and spiritual views of their citizens. In this way, Oregon has chosen to allow its citizens the freedom of personal and religious choice in deciding for each of themselves whether physician-assisted dying fits with their religious and spiritual beliefs.

Attorney General Ashcroft's Directive, which prohibits the use of controlled substances for these purposes, tramples not only on state sovereign authority but also on the greater freedom of religion and conscience that Oregon has chosen to grant its citizens. The Ashcroft Directive thus exceeds the Attorney General's authority under the CSA. The CSA does not grant the Attorney General the power to usurp traditional state powers to regulate medical practice or standards, and it certainly does not give the Attorney General power to encroach upon state religious freedom. Rather, the CSA addresses only the need to regulate controlled substances across state lines to protect against drug abuse.

At its core, this case is about social policy, religious freedom, and preserving the right to pursue one's individual beliefs about human dignity, personal autonomy, and spirituality. The heart of this case is the right of the states and their citizens to decide for themselves the weighty and intensely personal and spiritual question of whether to allow terminally ill patients to seek the aid of their physicians in dying as a means to relieve their pain and suffering and preserve their dignity in accordance with their own beliefs.

ARGUMENT

I. THE PEOPLE OF OREGON HAVE PROPERLY EXERCISED THEIR PREROGATIVE UNDER THE PRINCIPLES OF FEDERALISM TO ALLOW TERMINALLY ILL PATIENTS TO CHOOSE PHYSICIAN-ASSISTED DYING, UNDER HIGHLY CONTROLLED CIRCUMSTANCES, IN KEEPING WITH THEIR PERSONAL AND RELIGIOUS BELIEFS

A. The Decision to Seek a Physician's Assistance in Hastening One's Impending Death Is a Highly Personal and Religious Decision and Is Supported by a Substantial Body of Religious Thought and Doctrine

While it is true that some people believe that physician-assisted dying is immoral, sinful, or even dangerous, for many others, physician-assisted dying instead offers a necessary means to ending unnecessary suffering and to preserving human dignity and independence in a way that is neither immoral nor sinful, but is in keeping with the exercise of one's own beliefs and conscience. For the terminally ill, choosing how to confront death is an intensely personal decision. Anxieties over the loss of dignity and autonomy are integrally bound up with concerns about ensuring that the conditions of one's death reflect one's own deeply held religious and spiritual beliefs:

> Religion continues to be inextricably linked with death for many patients and families. Death compels us to confront the meaning of existence, mortality, and the possibility of a hereafter. Religion provides to some both answers and methods for resolving these issues. . . . Religiously-based ethical systems often provide normative guidance or even specific directives to resolve the dilemmas posed by the treatment choices of a dying or very ill patient.

Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITT. L. REV. 549, 560-61 (1997) (footnote omitted). For these reasons, this Court has emphasized that any question concerning "the right to die," such as that presented here, "is a perplexing question with unusually strong moral and ethical overtones." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 277 (1990).

The issues surrounding physician-assisted dying thus implicate a wide diversity of religious and spiritual liberty beliefs. There is no monolithic religious view in this country on the question of physician-assisted dying. *See, e.g.*, Melvin I. Urofsky, *Justifying Assisted Suicide: Comments on the Ongoing Debate*, 14 NOTRE DAME J.L. ETHICS & PUB. POL'Y 893, 913 (2000); GERALD A. LARUE, PLAYING GOD: FIFTY RELIGIONS' VIEWS ON YOUR RIGHT TO DIE 8 (1996); Matthew P. Previn, Note, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 GEO. L.J. 589, 596-601 (1996). "[I]ndividuals of different religious faiths make different judgments and choices about whether to live on under such circumstances." *Glucksberg*, 521 U.S. at 746 (Stevens, J., concurring). Terminally ill patients' interests in religious and spiritual freedom thus dictate that they be allowed to make this choice according to their own beliefs, unfettered by the religious beliefs of others. As Justice Stevens noted in *Glucksberg*, "[a]voiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly [a]t the heart of [the] liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." 521 U.S. at 745 (Stevens, J., concurring) (citation and internal quotation marks omitted).

Religious organizations and religious leaders have taken a wide variety of positions on the morality of physician-assisted dying, and some religious denominations have even expressly endorsed an individual's moral prerogative to choose assisted dying. For example, the United Church of Christ General Synod passed a resolution in 1991 entitled, "Rights and Responsibilities of Christians Regarding Human Death," in which the Church affirmed the right to choose how one's life should end. MINUTES OF THE UNITED CHURCH OF CHRIST SYNOD at 18 (1991); *see also* Reverend Robert K. Nace, Assisted Suicide: Whose Choice Is It? (Sept. 2000), http://www.ucc.org/ucnews/sep00/assist.htm ("We are created by God and our life is not ours to squander, to take away or wish away or to hang on too tightly. To hang onto too tightly is the idolatry of our life, a pervasive sin of our culture enhanced by the skill of modern medicine.").

Similarly, the Episcopal Diocese of Newark's Task Force on Assisted Suicide concluded that in many circumstances, physician-assisted dying "can be theologically and ethically justified" when a terminally ill person makes a voluntary and informed choice after all reasonable means of ameliorating his or her suffering have been exhausted. EPISCOPAL DIOCESE OF NEWARK, REPORT OF TASK FORCE ON ASSISTED SUICIDE, 9 (1996), *available at* http//www.dioceseofnewark.org/report.html. Indeed, the now-retired Bishop John Shelby Spong of the Episcopal Diocese of Newark strongly supports the rights of the terminally ill to choose physician-assisted dying:

> [T]he values marking the Christian faith and those motivating the "Death with Dignity" movement begin to merge. The key to this union lies in the commitment by both groups to defend the dignity and sacredness of human life. . . . Do we not serve our deepest convictions if we decide to end our life at the moment in which its sacredness becomes compromised? . . . As such we must also be responsible with God for guaranteeing the goodness of our deaths.

The Right Reverend John Shelby Spong, *Assisted Suicide: A Christian Choice and a New Freedom* (Feb. 12, 2003), *available at* http://www.beliefnet.com/story/121/story_12143_2.htm. Some in the Anglican Church have also adopted a similar stance. *See* Cynthia B. Cohen, *Christian Perspectives on Assisted Suicide and Euthanasia: The Anglican Tradition, in* PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE 335, 338 (Margaret P. Battin *et al.* eds. 1998) (noting that many believe that prolonged physical pain, depersonalization, loss of control, and bodily deterioration "serv[e] no discernible spiritual or other purpose" and "can be destructive of moral and spiritual values").

In 1988, the Unitarian Universalist Association became the first large denomination in North America to take an explicit stand in support of the right to die with dignity through assisted dying. The General Assembly of the Unitarian Universalist Association supports "the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths." GENERAL ASSEMBLY OF THE UNITARIAN UNIVERSALIST ASSOCIATION OF CONGREGATIONS, THE RIGHT TO DIE WITH DIGNITY (1988), *available at* http://www.uua.org/actions/health/88die-dignity.html; *see also* REV. RALPH MERO, PAMPHLET, CHOICES IN DYING, *available at* http://www.uua.org/ pamphlet/3100.html (last visited 7/15/05) ("[M]any Unitarian Universalists accept assisted suicide as an option for terminally ill patients or others struggling in conditions of irreversible suffering and hopeless deterioration.").

Various branches of Judaism also teach sympathy, understanding, and respect for those who choose assistance in hastening death, and some Jewish organizations take the position that a competent, terminally ill adult has the right to hasten death voluntarily with the aid of a physician. *See, e.g.*, Press Release, Yes on AB 654, Diverse Group of Clergy Supports California Compassionate Choices Act (May 26,

2005) ("What is most important is for people to know they have a choice, and to enable them to make the best end-of-life decisions for themselves.") (quoting Rabbi Joshua Stampfer); Noam J. Zohar, *Jewish Deliberations on Suicide: Exceptions, Toleration, and Assistance*, *in* Battin *et al.* 362, 368 (explaining that some Jewish teachings allow "any person finding himself in dire strai[t]s . . . to seek escape through suicide").

In addition, a variety of Protestant denominations that have not adopted any formal position on physician-assisted dying do encourage compassion, sympathy, and support for those who choose this option. For example, the Presbyterian Church has endorsed the view that "basic Christian respect for persons demands that a person's decisions about death be honored in most instances." PRESBYTERIAN CHURCH (U.S.A.), CHRISTIAN FAITH AND LIFE AREA, CONGREGATIONAL MINISTRIES DIVISION, IN LIFE AND IN DEATH WE BELONG TO GOD: EUTHANASIA, ASSISTED SUICIDE, AND END-OF-LIFE ISSUES 47 (1995) (citing 195th General Assembly position on "The Covenant of Life and the Caring Community" (1983)); *see also* Press Release, Yes on AB 654, *supra* ("When we live as though death is the worst thing that can happen to us, we lose the zest for living. The [California] Compassionate Choices Act allows one to have a 'good death'.") (quoting Rev. Paul Smith of the First Presbyterian Church of Brooklyn, New York). The United Methodist Church has adopted a similar approach. *See* UNITED METHODIST CHURCH, BOOK OF RESOLUTIONS 144 (1992).

Yet other traditions of religious thought and freedom of conscience also affirmatively support an individual's right to seek physician-assisted dying. "Both Buddhism and Shintoism permit suicide when an individual with an incurable disease is in pain." Previn, Note, *supra*, at 597 (footnotes omitted). Likewise, the humanist tradition endorses the ethical viewpoint that because every individual has the right to live with dignity, every individual has the right to die with dignity, and physician-assisted dying is

therefore a legitimate moral choice in certain circumstances. *Id.* at 599.

In keeping with this support for physician-assisted dying, polls demonstrate that the vast majority of Americans of all faiths support physician-assisted dying. A national 2001 poll revealed that a majority of 61% to 34% of adults would favor enacting a law like Oregon's in their states, and 58% versus 35% believed that Attorney General Ashcroft was wrong to try to overrule the ODWDA. Press Release, Harris Interactive Survey (Jan. 9, 2002). By a majority of 65% to 29%, those surveyed also thought that "the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended." *Id.* And with regard to individual states:

- In California, 65% of Catholics, 63% of Protestants and other Christians, and 83% of those of other faiths believe that incurably ill patients should have the right to ask for and receive life-ending medication. Press Release, Field Research Corp. (Mar. 2, 2005);
- 72% of Vermont adults believe that the decision about whether they should be able to bring a peaceful end to their own suffering should be theirs and "not God's." Press Release, Zogby Int'l (Jan.6, 2005).

Indeed, even within religions that institutionally oppose physician-assisted dying, many individual members hold a different view consistent with their own religious beliefs. *See, e.g.*, Belden Russonello & Stewart, *The View from Mainstream America: The Catholic Voter in Summer 2004* at 58 (July 2004) (showing that 53% of Catholic voters support physician assistance in dying); Daniel C. Maguire, *Introduction: Charles C. Curran: Catholic Theologian, Priest, Prophet*, *in* A CALL TO FIDELITY: ON THE MORAL THEOLOGY OF CHARLES E. CURRAN 8 (J. Walter *et al.* 2002) ("There is 'a legitimacy of ethical pluralism within Catholic moral theology' on the subject of assisted suicide. 'Catholic theology' is not simply Vatican theology, since Catholic theology is broader and more nuanced.") (citations omitted); Cristina L.H. Traina, *Pope & John Lecture on*

Professionalism: Religious Perspectives on Assisted Suicide, 88 J. CRIM. L. & CRIMINOLOGY 1147, 1151 (1998) ("Even within those religious bodies in which concord or autocratic authority is strong enough to generate a position, there are conscientious people who dissent."). In fact, over a hundred clergy from nine denominations and faith communities support California's Compassionate Choices Act, which is similar to the ODWDA. Press Release, Yes on AB 654, *supra*.

This vast array of views on assisted dying demonstrates its significant support within and throughout the religious community. The ODWDA thus protects Oregon citizens' freedom to exercise their own religious and spiritual beliefs by allowing them to decide for themselves whether physician-assisted dying comports with those beliefs.

B. This Court Previously Ruled That the Decision Whether to Allow the Terminally Ill to Seek a Physician's Assistance in Hastening One's Impending Death Properly Belongs to the Individual States Under Principles of Federalism

As this Court held in *Glucksberg*, the issues surrounding physician-assisted dying implicate a number of state interests. *Glucksberg*, 521 U.S. at 728-35. It is therefore up to the states to decide how to weigh those various and sometimes conflicting interests—and, in turn, how to treat the ultimate issue of physician-assisted dying as a matter of state law. *Id.* at 735. Certainly, one of those state interests lies in "protecting the integrity and ethics of the medical profession." *Id.* at 731. Another is an interest in "the preservation of human life" and in protecting vulnerable groups such as the poor, the elderly, the disabled, and the terminally ill. *Id.* at 728, 731-32; *see also Addington v. Texas*, 441 U.S. 418, 426 (1979) (noting that a state "has a legitimate interest under its *parens patriae* powers" to decide how best to provide for its more vulnerable citizens). And the states also have an undeniable interest in protecting an individual's "liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of

human life" according to his or her own religious beliefs. *Glucksberg*, 521 U.S. at 745 (Stevens, J., concurring) (citation and internal quotation marks omitted).

None of these interests is absolute. Rather, state citizens and state legislatures have the discretion and duty to balance these interests. In a federal system, different states will strike the balance differently. Indeed, in *Cruzan*, this Court emphasized that it is up to the states to make policy-based decisions regarding their citizens' rights to die: "The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe [the States] may legitimately seek to safeguard the personal element of this choice . . . ." 497 U.S. at 281. Thus, "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy," and instead weigh its interest in the preservation of human life against the "the constitutionally protected interests of the individual." *Id.* at 282; *see also id.* at 293 n.1 (Scalia, J., concurring) (emphasizing that with regard to the right to die, "it is up to the citizens of [the States] to decide, through their elected representatives, whether that wish will be honored"). This is particularly true with regard to questions such as the right to die, which "is a perplexing question with unusually strong moral and ethical overtones." *Id.* at 277.

The Court in *Glucksberg* therefore quite pointedly refused to "place the matter outside the arena of public debate and *legislative* action," lest it simply become "transformed into the policy preferences" of a few individuals. 521 U.S. at 720 (emphasis added). Instead, the Court expressed its hope that the debate over physician-assisted dying would continue in the states. "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Id.* at 735.

Accordingly, with regard to physician-assisted dying, "'the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the

"laboratory" of the States . . . in the first instance.'" *Id.* at 737 (O'Connor, J., concurring). This Court has long recognized that the role of the states in acting as laboratories of social and economic innovation constitutes a critical component of our federalist system. As Justice Brandeis wrote in his oft-quoted dissent in *New State Ice Co. v. Liebmann*, "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting); *accord EEOC v. Wyoming*, 460 U.S. 226, 265 (1983) (Burger, C.J., dissenting). The virtues of state experimentation are particularly evident in areas involving "problems of vital local concern," such as medical care and regulation of the medical profession. *Whalen v. Roe*, 429 U.S. 589, 597 (1977). State experimentation is also of particular value on "difficult questions of policy," *Smith v. Robbins*, 528 U.S. 259, 272 (2000); *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 50 (1973), such as physician-assisted dying, which concerns not only an individual's fundamental interests in human dignity and relief from pain and suffering but also a wide diversity of religious and spiritual liberty interests as well, *Glucksberg*, 521 U.S. at 746-47 (Stevens, J., concurring).

The "earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide" is therefore precisely the kind of difficult policy question that is best left to state experimentation and therefore reserved to the states in this Court's decision in *Glucksberg*. *Id.* at 735. As the Court explained in *Glucksberg*, the states are especially well-suited to advancing the debate over physician-assisted dying. They "have superior opportunities to obtain the facts necessary for a judgment about [physician-assisted dying]." *Id.* at 788 (Souter, J., concurring); *see also Barsky v. Bd. of Regents*, 347 U.S. 442, 449 (1954) (noting that the states have much greater experience in supervising medical practice and establishing

detailed procedures for doing so). In addition, they have "the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions." *Glucksberg*, 521 U.S. at 788 (Souter, J., concurring). Indeed, "experimentation . . . is entirely proper, as well as highly desirable" in the ongoing debate over physician-assisted dying. *Id.* at 789 (Souter, J., concurring).

C. The ODWDA Allows Oregon to Protect Individual Religious Freedom at a Level Its Citizens Deem Appropriate

Physician-assisted dying necessarily entails the states' sovereign power to protect not only their citizens' substantial liberty interests in dignity, independence, and relief from suffering, but also their citizens' substantial religious liberty interests in keeping this decision free from governmental interference. Accordingly, consistent with the Court's suggestions in *Glucksberg*, the people of Oregon have carried forward the debate over physician-assisted dying. Oregonians engaged in exactly the kind of "extensive and serious evaluation of physician-assisted suicide" suggested in *Glucksberg*, *id.* at 737 (O'Connor, J., concurring), and for a second time approved the ODWDA as a legitimate means to protect the personhood, dignity, and spiritual interests and autonomy of terminally ill patients in Oregon by enabling them to relieve their own suffering and leave life in the way that best comports with their beliefs.

Much of the debate surrounding physician-assisted dying concerns the various religious and moral views about "the sanctity of life" and how best to protect it. *See, e.g.*, Boozang, *supra*, at 565-98; Previn, Note, *supra*. As this Court acknowledged in *Glucksberg*, one of the bases for the Anglo-American tradition of prohibiting suicide is the idea that "'[suicide] is an Offence against Nature, against God, and . . . is contrary to Nature and a Thing most horrible.'" 521 U.S. at 712 n.10. Indeed, the inherently and deeply religious and spiritual nature of the issue can already be seen from looking at the identities of the various *amici* who have filed in support of the petitioner. *See, e.g.*, Br. of Focus on

the Family & the Family Research Council; Br. of the U.S. Conf. of Catholic Bishops *et al.*; Br. of the Christian Med. Ass'n *et al.*; Br. of the Catholic Med. Ass'n.

The freedom to choose physician-assisted dying, then, constitutes in large part a freedom of religious choice—specifically, freedom from the imposition of others' religious beliefs in a way that restricts one's fundamental and deeply personal choices about how the last moments of one's life should be lived. *See* Penney Lewis, *Rights Discourse and Assisted Suicide*, 27 AM. J.L. & MED. 45, 60 (2001) ("[F]or the state to interfere in the moral decision of an individual to take her life violates her right to freedom of conscience."); Urofsky, *supra*, at 942 ("[T]here is no justifiable reason why one religion or one group or one individual should be able to impose their views on others."); Bishop Spong, *supra* ("[T]he basic human right to choose how and when to die should be guaranteed by law and respected by our communities of faith."). Thus, by protecting the interests of Oregonians in relief from suffering and death in a manner that best comports with their beliefs, the ODWDA represents a state's choice to protect individual exercise of freedom of religion and conscience. Oregon's authority to promulgate such a measure should therefore be respected.

Indeed, it is a basic principle of "Our Federalism" that, regardless of the exact contours of an individual's rights under the Establishment and Free Exercise Clauses (or the other parts of the federal Constitution), the states are allowed to provide their citizens with even greater protections than those afforded under the federal Constitution. *See PruneYard Shopping Ctr. v. Robins*, 447 U.S. 74, 81 (1980) (noting that a state may "exercise its police power or its sovereign right to adopt in its own Constitution individual liberties more expansive than those conferred by the Federal Constitution"); *Cooper v. California*, 386 U.S. 58, 62 (1967) (similar); *see also Gillette v. United States*, 401 U.S. 437, 453 (1971) ("Quite apart from the question whether the Free Exercise Clause might require some sort of exemption, it is hardly impermissible for Congress to attempt to

accommodate free exercise values . . . .") (footnote omitted). In fact, the Court's decision in *Glucksberg* on this very issue strongly suggests that, even if a fundamental liberty interest in physician-assisted dying does not exist under the Fourteenth Amendment of the federal Constitution, such a right could very well exist under a state constitution or be granted by state law. 521 U.S. at 735; *see also* Gary S. Gildin, *A Blessing in Disguise: Protecting Minority Faiths Through State Religious Freedom Non-Restoration Acts*, 23 HARV. J.L. & PUB. POL'Y 411, 436 (2000) (interpreting *Glucksberg* to mean that "the judgment to maximize the free exercise of religion is entirely consistent with the constitutional scheme that empowers each state to resolve the debate over affording rights, above the threshold fixed by the Constitution, as the majority sees fit").

Such state prerogatives to grant enhanced religious freedoms also spring in part from the role of the states as "experimental laboratories" under the principles of federalism. "'States, while bound to observe strict neutrality, should be freer to experiment with involvement [in religion]—on a neutral basis—than the Federal Government'" and in this way "strike a proper balance" between the demands of the Constitution "on the one hand and the federalism prerogatives of States on the other." *Zelman v. Simmons-Harris*, 536 U.S. 639, 678-79 (2002) (Thomas, J., concurring) (quoting *Walz v. Tax Comm'n of City of New York*, 397 U.S. 664, 699 (1970) (Harlan, J., concurring)) (footnote omitted). The states are thus free to draw "a more stringent line" as to what they consider necessary for freedom of religion than does the federal Constitution. *See Locke v. Davey*, 540 U.S. 712, 721-22 (2004).

The ODWDA permits terminally ill Oregonians to depart life in a way that best comports with their spiritual beliefs. Those individuals who believe that physician-assisted dying is a moral and spiritually legitimate or even required choice may do so according to the dictates of their consciences and their beliefs. Those who believe that physician-assisted

dying is not a moral or ethical choice also have the freedom to follow their own consciences and beliefs by not choosing this option. In this way, Oregon has elected to protect the religious freedoms and spiritual interests of all of its citizens. As Justice Stevens remarked in *Cruzan*, "not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience." 497 U.S. at 343 (Stevens, J., dissenting). By stepping in and making the unilateral decision to override Oregon's sovereign choice in the matter, the Attorney General plainly interfered with Oregon's authority to experiment with the difficult moral, religious, and other policy questions implicated by physician-assisted dying.

D. The Attorney General Has No Authority Simply to Adopt One Particular Social or Religious View and Override Oregon's Exercise of Its Federalism-Based Authority

1. Because Regulation of Medical Practices Is a Traditional State Power, a Federal Agency Can Regulate Medical Practices Only Under Clear Congressional Authorization

Regulation of the practice of medicine, and in particular, regulation of the standards of reasonable medical care, is a traditional state power. "[T]he field of health care [is] a subject of traditional state regulation." *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000); *accord Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996); *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). "It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power [and] extends naturally to the regulation of all professions concerned with health." *Barsky*, 347 U.S. at 449. Indeed, eighty years ago the Court called it "[o]bvious[]" that "direct control of medical practice in the states is beyond the power of the Federal Government."

Linder v. United States, 268 U.S. 5, 18 (1925). More recently, the Court has stated that it is "well settled that the State has broad police powers in regulating the administration of drugs by the health professions." *Whalen*, 429 U.S. at 603 n.30.

In this case, the Attorney General claims that the CSA grants him the authority to regulate what qualifies as a "legitimate medical purpose" in each state and has declared that physician-assisted dying is not a "legitimate medical purpose" anywhere (but with specific reference to Oregon) for substances controlled under the CSA. *See* Pet. App. 102a (interpreting 21 C.F.R. § 1306.04(a)). Because regulating standards of reasonable medical care is a traditional state power, however, the Attorney General must identify a "clear and manifest" statement of congressional intent to grant him such authority under the CSA. *See Will v. Mich. Dep't of State Police*, 491 U.S. 58, 65 (1989) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

As this Court has repeatedly made clear with regard to federal agency incursion into traditional state powers such as the practice of medicine:

> Where an administrative interpretation of a statute invokes the outer limits of Congress' power, we expect a clear indication that Congress intended that result. This requirement stems from our prudential desire not to needlessly reach constitutional issues and our assumption that Congress does not casually authorize administrative agencies to interpret a statute to push the limit of congressional authority. This concern is heightened where the administrative interpretation alters the federal-state framework by permitting federal encroachment upon a traditional state power. Thus, "where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress."

Solid Waste Agency of N. Cook County v. U.S. Army Corps of Eng'rs, 531 U.S. 159, 172-73 (2001) (citing *Edward J.*

DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council, 485 U.S. 568, 575 (1988)); *accord Automated Med. Labs.*, 471 U.S. at 715-16. As demonstrated below, the Attorney General has no such authority.

2. Neither the CSA Nor *Oakland Cannabis* Provides the Attorney General with the Authority Unilaterally to Impose His Own Social/Religious View to Override Oregon's Decision To Sanction Physician-Assisted Dying

The CSA does not give the Attorney General the authority to impose his social policy agenda on states such as Oregon that have, through the democratic process, chosen to protect the spiritual and autonomy interests of the terminally ill. The CSA does not address standards of medical care or accepted medical procedures, much less the social or religious ramifications of physician-assisted dying; it instead speaks only to the safe classification and distribution of controlled substances as part of interstate commerce to protect against drug abuse and "quack" medicines. *See* 21 U.S.C. § 801; *see also* Reno Letter, *supra*. Neither the plain language nor the purpose of the CSA invests the Attorney General with such sweeping authority to override Oregon's considered policy choice under the guise of regulating "legitimate medical purposes."

A federal agency's authority to override traditional state authority is dependent on Congress' intent:

> First, an agency literally has no power to act, let alone pre-empt the validly enacted legislation of a sovereign State, unless and until Congress confers power upon it. Second, the best way of determining whether Congress intended the regulations of an administrative agency to displace state law is to examine the nature and scope of the authority granted by Congress to the agency. . . . An agency may not confer power upon itself. To permit an agency to expand its power in the face of a congressional limitation on its jurisdiction would be to grant to the agency power to override Congress. This we are both unwilling and unable to do.

La. Pub. Serv. Comm'n v. FCC, 476 U.S. 355, 374-75 (1986); *accord City of New York v. FCC*, 486 U.S. 57, 64 (1988).

As this Court noted in its recent decision in *Gonzales v. Raich*, "[t]he main objectives of the CSA were to conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances." 125 S. Ct. 2195, 2203 (2005). Drugs are therefore scheduled according to their high potential for abuse, lack of any accepted medical use, and absence of safety for use in medically supervised treatment. *Id.* at 2203-04. The CSA and its implementing regulations set forth strict requirements regarding registration, labeling and packaging, production quotas, drug security, and recordkeeping. *Id.* at 2204. The CSA does not, however, give the Attorney General the authority to regulate the practice of medicine, an area traditionally reserved to the states. *See Pegram*, 530 U.S. at 237. The CSA says nothing about standards of care, licensing, medical ethics, accepted medical procedures, and the like. Indeed, given the states' elaborate regimes that regulate the practice of medicine, *see, e.g., id.* at 237, it would be extremely odd for Congress to have intended to silently displace such state regulation.

The CSA is thus a law enforcement statute, not a medical policy act.[2] Accordingly, the CSA should not, under principles of both federalism and federal deference to state

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[2] Indeed, if the 105th and 106th Congresses had believed that the CSA reaches the use of controlled substances in physician-assisted dying, they would not have introduced the Lethal Drug Abuse Prevention Act of 1998, *see* S. 2151, 105th Cong. (1998), or the Pain Relief Promotion Act of 1999, *see* H.R. 2260, 106th Cong. (2000), both of which, had they passed, would have specifically expanded the scope of the CSA to nullify the ODWDA. It is thus apparent that, after this Court's decision in *Glucksberg*, at least some members of Congress viewed the CSA as not speaking to the use of controlled substances in physician-assisted dying.

power, be construed to allow the Attorney General to make pronouncements based on unilateral judgments about the social value of various medical practices using perfectly legal drugs of known medical efficacy. This Court should thus "read the statute as written to avoid the significant constitutional and federalism questions raised by respondents' interpretation, and therefore reject the request for administrative deference." *Solid Waste Agency of N. Cook County*, 531 U.S. at 174 .

For these same reasons, it is plain that this Court's decision in *Oakland Cannabis* did not hold that the CSA gives the Attorney General authority to define what constitutes a "legitimate medical purpose." *See* 532 U.S. at 493. In *Oakland Cannabis*, the first challenge to California's legalization of medical marijuana use, the Court rejected the argument that federal law required a "medical necessity" exception to the CSA's ban on marijuana, finding that the CSA precludes such an exception. *Id.* at 493-95. Extrapolating from the Court's decision in *Oakland Cannabis*, the Department of Justice's Office of Legal Counsel ("OLC") reasoned that, like California's medical marijuana law, the ODWDA must also be an attempt to "abrogate" or "supersede" the CSA. Pet. App. 131a, 133a-134a. In a June 2001 opinion written at the Attorney General's request, the OLC therefore characterized Oregon as attempting "by its unilateral action, [to] take its physicians' conduct out of the scope of otherwise nationally applicable prohibitions on the dispensing of controlled substances." Pet. App. 134a.

Oakland Cannabis, however, is inapposite to this case. For one thing, the California statute at issue in *Oakland Cannabis* is entirely different from the ODWDA. In no way does the ODWDA attempt to "abrogate" or "supersede" federal law. Oregon has not sought to legalize what the CSA has expressly banned or to challenge the CSA's classification scheme—how could it, when the CSA says nothing about physician-assisted dying or the use of controlled substances for this purpose? Rather, Oregon has

simply legalized a medical practice that uses drugs already fully authorized for medical use under the CSA. For another thing, *Glucksberg* preserves the individual states power to regulate through the political process the issue of whether physician-assisted dying is a "legitimate medical purpose." 521 U.S. at 735. Indeed, the ODWDA is likely the kind of duly enacted state statute, well within Oregon's sovereign power and well outside the CSA, that Justice Stevens anticipated when he stated, in *Oakland Cannabis*, that the federal government must "show[ ] respect for the sovereign States that comprise our Federal Union. That respect imposes a duty on federal courts, whenever possible, to avoid or minimize conflict between federal and state law, particularly in situations in which the citizens of a State have chosen to serve as a laboratory in the trial of novel social and economic experiments without risk to the rest of the country." 532 at 502 (Stevens, J., concurring) (quotation marks omitted).

For these reasons, as an agency interpretation of federal law the Ashcroft Directive merits neither *Chevron* nor *Skidmore* deference. Under *Chevron*, a court should defer to agency interpretations of a statute only if the agency was granted authority to render such interpretations—and even then, often only if the agency has expertise in the area and has been consistent in its interpretation, among other considerations. *See Barnhart v. Walton*, 535 U.S. 212, 222 (2002) (discussing *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984)); *United States v. Mead Corp.*, 533 U.S. 218, 231-34 (2001) (same). And in all events, *Chevron* deference does not apply to informal interpretive rulings, such as the Ashcroft Directive. *Christensen v. Harris County*, 529 U.S. 576, 587 (2000).

Similarly, the lesser deference accorded under *Skidmore* depends upon, among other things, the validity, persuasiveness and consistency of the agency's interpretation of its authority. *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). As a purported agency interpretation of the CSA, the Ashcroft Directive obviously fails under both *Chevron* and *Skidmore*.

First, the CSA in no way provides any "clear statement" that the Attorney General has the authority to ban all use of controlled substances in physician-assisted dying—indeed, the CSA does not speak to standards of medical care at all, much less speak to such value-laden issues of public policy as assisted dying.

Second, the Attorney General has no expertise in the areas of medical practice, standards medical of care, social policy with respect to medical care, much less expertise on the individual spiritual choices of terminally ill patients. *See* 21 U.S.C. § 811(b) (denying the Attorney General the power to make medical or scientific decisions with regard to drug control).

Third, under the previous administration, Attorney General Reno made plain that the CSA does not in any way speak to the OWDWA. *See Bates v. Dow Agrosciences LLC*, 125 S. Ct. 1788, 1801 (2005) (finding agency's claim of pre-emptive authority under statute "particularly dubious" where five years earlier the government had repudiated such an interpretation of the statute).

Finally, as noted by the Patient-Respondents (Br. at 15-19), neither Attorney General Ashcroft nor the OLC considered the substantial body of information, including comprehensive annual reports, about the actual practices of physicians and experiences of patients under the procedures enacted in the ODWDA.

3. Considerations of Federalism and Religious Freedom Point to Invalidating the Attorney General's Directive and Leaving Oregon's Law As Is

The Ashcroft Directive impermissibly burdens Oregon's efforts to create a regime of personal and religious choice and freedom and instead simply imposes on the entire polity only one select set of religious and personal beliefs about the issue. By establishing an absolute proscription on physician-assisted dying via the use of controlled substances, the Attorney General has thus prematurely ended democratic

debate among the states and the people on this issue in a way that was never authorized under the CSA. *See Glucksberg*, 521 U.S. at 735 (refusing "to place the matter [of assisted suicide] outside the arena of public debate and *legislative* action," lest it simply become "transformed into the policy preferences" of a few individuals) (emphasis added).

The people of Oregon have sought to enhance religious freedoms, rather than restrict them, while the Attorney General has sought impermissibly to burden Oregon's right to do so under the principles of federalism. Oregon was acting within its sovereign authority in not only regulating medical practices and standards within the states but also in further protecting religious freedoms. "We do not see any reason why important individual interests should be afforded less protection simply because the government finds itself in the position of defending them." *Cruzan*, 497 U.S. at 282 n.10. Moreover, the ODWDA is entirely consistent with this Court's holding that policy choices regarding physician-assisted dying should be an issue commended to the discretion of the individual states as "laborator[ies]." 521 U.S. at 737 (O'Connor, J., concurring). The ODWDA thus not only allows federalism to flourish but also protects individual religious freedom.

All of these factors strongly militate against any idea that Congress meant the CSA to trump the states' sovereign authority in this regard. The Court has been particularly protective of state sovereignty when federal law prevents "the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise." *United States v. Lopez*, 514 U.S. 549, 583 (1995) (Kennedy, J., concurring). Thus, the ODWDA is a legitimate exercise of the authority reserved to Oregon under the principles of federalism by this Court in *Glucksberg*. And although the voter initiative in Oregon is the only one that has been successful thus far, at least twenty-five similar proposals have been made in twenty other states. *See, e.g.*, A.B. 654, 2005-2006 Reg. Sess. (Cal. 2005) ("California Compassionate Choices Act"); H. 168,

2005-2006 Reg. Sess. (Vt. 2005) ("Vermont Death With Dignity Act").

Indeed, because religious and personal beliefs about physician-assisted dying are hardly monolithic, there is, at this point, no basis on which the Attorney General could have set forth a national policy on this issue. To have done so was thus tantamount to allowing the Attorney General to set moral and religious policy for the entire country. "[I]n deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject." *Cruzan*, 497 U.S. at 277-78. Rather, as Justice Scalia emphasized in *Cruzan*, with regard to the right to die, "it is up to the citizens of [the States] to decide, through their elected representatives, whether that wish will be honored." *Id.* at 293 (Scalia, J., concurring). The Attorney General's attempt single-handedly to overrule Oregon's decision thus impermissibly interferes with not only Oregon's authority under principles of federalism but also the religious and personal freedom that Oregon has granted its citizens under that authority.

II. THOSE WHO SEEK TO OVERTURN THE ODWDA IGNORE THE INTERESTS IN HUMAN DIGNITY, INDIVIDUAL AUTONOMY, AND RELIGIOUS AND SPIRITUAL FREEDOM THAT IT REPRESENTS

A. There Is No Consensus Religious View Regarding the Morality and Religious Implications of Physician-Assisted Dying

Petitioner and *amici* such as the United States Conference of Catholic Bishops *et al.*, argue that the Attorney General's directive is consistent with age-old religious views on physician-assisted dying. Gov't Br. at 23; Br. of U.S. Conf. of Catholic Bishops *et al.* at 2. In so asserting, they effectively presume that the entirety of the American religious community, as well as most of Western civilization,

considers physician-assisted dying to be immoral. That presumption is ill-founded and erroneous.

As the discussion above in Part I.A. explains, belief in the preservation of life at all costs are hardly uniform across all religions or even across all adherents of any given religion. As the Supreme Court has emphasized, and as the very existence of the ODWDA itself demonstrates, there is a great deal of debate and divergence of views with regard to this issue. The great diversity in religious and moral thought on physician-assisted dying is matched only by the great diversity of religious faiths in this country.

- Although the Catholic Church may frown upon physician-assisted dying on the one hand, the United Church of Christ and the Unitarian Universalist Association support an individual's right to choose this option.
- Various branches of Judaism also teach sympathy, understanding, and respect for those choose assistance in dying.
- The Presbyterian and Methodist Churches have similarly endorsed respect for the terminally ill patient's choices about how to die.
- And even within faiths, many congregants disagree about the morality of physician-assisted dying, with many supporting it as a legitimate and moral choice. Indeed, even a majority of Catholics support physician-assisted dying.

The Attorney General's Directive overlooks this diversity of religious thought (as well as the similar diversity of medical views addressed by other *amici*) and simply imposes the views of one group on all in violation of religious freedom.

B. The ODWDA Protects the Rights of the Terminally Ill and Affords All of Oregon's Citizens to Exercise Their Religious Freedom Consistent with Their Own Beliefs

Amici such as the Catholic Medical Association and the Christian Medical Association *et al.*, argue that the practice

of medicine necessarily must protect the right to preserve life at all costs and in any event must protect the disabled. The *amici* for Petitioner thus suggest that no one could reasonably seek physician-assisted dying as a legitimate form of "medical care." Br. of Catholic Med. Ass'n at 8-10; Br. of Christian Med. Ass'n at 6; *see also* Br. of Americans United for Life at 10-16; Br. of Not Dead Yet *et al.*, *passim*; Br. of Liberty Counsel at 3-7, 17-18.

These *amici* are wrong. There is no consensus of thought on these issues: Many believe that physician-assisted dying, under very controlled circumstances, in fact *protects* the rights of the terminally ill by honoring their interests in personal autonomy and dignity and by honoring their personal and spiritual beliefs about the end of life.

> Individuals of different religious faiths make different judgments and choices about whether to live on under such circumstances. . . . Allowing the individual, rather than the State, to make judgments "about the quality of life that a particular individual may enjoy" does not mean that the lives of terminally ill, disabled people have less value than the lives of those who are healthy. Rather, it gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her.

Glucksberg, 521 U.S. at 746-47 (Stevens, J., concurring) (citations omitted).

Many also believe that, in addition to protecting the interests of the terminally ill and honoring their beliefs, the assistance of a physician in ending one's pain and suffering peacefully through the prescription of medication does qualify as legitimate and professional medical practice. *See, e.g.*, Boozang, *supra*, at 565-98; Urofsky, *supra*, at 919-20. Terminally ill patients seeking to end their lives through the assistance of a physician do so not only because of the physical pain they suffer but also because of the mental and psychological toll of terminal illness and because of their fundamental interests in preserving their own autonomy and

dignity in a manner that comports with their personal and spiritual beliefs. They seek their physicians' aid in this endeavor not just for their ability to prescribe medication but also for their succor and support. "[T]he Court [has] recognized that the good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more than treat symptoms, one who ministers to the patient. This idea of the physician as serving the whole person is a source of the high value traditionally placed on the medical relationship." *Glucksberg*, 521 U.S. at 779 (Souter, J., concurring) (citations omitted).

C. The States Should Be Allowed to Decide for Themselves How to Weigh Their Citizens' Religious and Other Interests Against Any Feared Problems from Physician-Assisted Dying

Amici such as the Thomas More Society and the United States Conference of Catholic Bishops *et al.* protest that the ODWDA will lead our society down a slippery slope to a parade of horribles and that the Attorney General was therefore authorized to regulate physician-assisted dying. Br. of Thom. More Soc'y at 19-26; Br. of U.S. Conf. of Catholic Bishops *et al.* at 12-18.

The Court has rejected many such "parade of horribles" and "slippery slope" arguments before, however, and with good reason. *See, e.g.*, *Atwater v. City of Lago Vista*, 532 U.S. 318, 353 n.25 (2001); *Whalen*, 429 U.S. at 600-602. As the Court in *Glucksberg* recognized, it is up to the states to establish and enforce adequate safeguards to protect against such a parade of horribles. "We agree that the case for a slippery slope has been made out, but—bearing in mind Justice Cardozo's observation of '[t]he tendency of a principle to expand itself to the limit of its logic,'—we also recognize the reasonableness of the widely expressed skepticism about the lack of a principled basis for confining the right." 521 U.S. 733 n.23.

With regard to questions involving the right to die, "[a] State is entitled to guard against potential abuses in such situations." *Cruzan*, 497 U.S. at 281. Indeed, as Justice O'Connor stated, "[t]here is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure." *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring). Accordingly, the people of Oregon, as is their prerogative, have decided that their interests in human dignity, individual autonomy, and religious and spiritual freedom outweigh the potential problems of physician-assisted dying and have decided which safeguards they believe are necessary to allow people to leave life in the way that best comports with their beliefs.

* * * * *

As *amicus* Reverend Ken Phifer reflected on his own experience in counseling a terminally ill member of his congregation when she decided to hasten her own death:

> [D]octors cannot always be healers. Each of us will come to a point in life when no medical treatment will help us, save perhaps to relieve our pain. At that point, when our condition is terminal, what we need more than anything else is intelligent compassion. We need people who understand the pain in our bodies and the suffering in our souls. Compassion may well be to give us drugs and apply therapies to make our bodies feel better. But for some of us, compassion may well be to help ease us into death.

Rev. Kenneth W. Phifer, A Hastened Death, Presentation at the Final Exit Network Conference (Nov. 14, 2004), *available at* http://www. finalexitnetwork.org/hastened_ death.htm.

CONCLUSION

For the foregoing reasons, the *Amici Curiae* respectfully request that the judgment of the Ninth Circuit be affirmed.

Respectfully submitted,

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APPENDIX

IDENTIFICATION OF *AMICI CURIAE*

THE AMERICAN ETHICAL UNION ("AEU") is a national organization of Ethical Culture societies and is part of a humanistic religious and educational movement inspired by the ideal that the supreme aim of human life is working to create a more humane society. The AEU's faith is in the capacity and responsibility of human beings to act in their personal relationships and in the larger community to help create a better world. The AEU's commitment is to the worth and dignity of the individual, and to treating each human being so as to bring out the best in him or her.

THE AMERICAN HUMANIST ASSOCIATION ("AHA"), founded in 1941, is the oldest and largest humanist organization in the nation, dedicated to ensuring a voice for those with a positive, nontheistic outlook. Humanism is a progressive philosophy of life that, without supernaturalism, affirms the ability and responsibility of human beings to lead ethical lives of personal fulfillment that aspire to the greater good of humanity. The mission of the AHA is to promote the spread of humanism, raise public awareness and acceptance of humanism, and encourage the continued refinement of the humanist philosophy.

AMERICANS FOR RELIGIOUS LIBERTY ("ARL") is a nonprofit public interest educational organization, founded in 1982, dedicated to defending religious liberty, freedom of conscience, and the constitutional principle of separation of church and state. ARL has participated as an amicus in other cases in this Court, including *Glucksberg v. Washington* and *Vacco v. Quill.*

THE CONGRESS OF SECULAR JEWISH ORGANIZATIONS ("CSJO") comprises several independent organizations whose unity of purpose is a secular expression of Jewish heritage, with particular emphasis on the cultural and ethical precepts of Jewish learning. The CSJO seeks to forge a Jewish identity that is

grounded in contemporary life and is committed to the social values of justice, peace, and community responsibility.

THE SHALOM CENTER is a national network (with offices in Philadelphia, Pennsylvania) that draws on Jewish wisdom of the past and present to address issues of social justice, peace, healing of the earth, and spiritual search—so as to voice a new prophetic agenda in Jewish, multireligious, and American life.

THE SOCIETY FOR HUMANISTIC JUDAISM ("SHJ"), established in 1969, includes more than fifty communities and is the central body for the Humanistic Jewish Movement in North America. The SHJ assists in organizing and supporting congregations and in providing a worldwide voice for its members, and is dedicated to the promotion of Jewish and humanistic ideals, including human dignity, integrity, tolerance, and equal treatment.

THE UNITARIAN UNIVERSALIST ASSOCIATION is a religious association of more than 1,000 congregations in the United States and Canada. In 1988, the Association adopted a resolution affirming the right to self-determination in dying and supporting the elimination of civil and criminal penalties against those who, under proper safeguards, assist terminally ill patients in selecting the time and manner of their own deaths.

THE UNITED CHURCH OF CHRIST JUSTICE AND WITNESS MINISTRIES is an organization within the United Church of Christ, one of the most diverse Christian churches in the United States that comprises a membership of over 1.4 million. The Justice and Witness Ministries is faith-based movement for peace, justice, equality, and inclusivity, and whose goals are compassion, advocacy and reconciliation.

FATHER JERRY R. ANDERSON, Episcopal Priest and Director of Pastoral Care at the Good Samaritan Hospital in Los Angeles, California.

THE REVEREND J. EDWIN BACON, Rector of the All Saints Episcopal Church in Pasadena, California.

THE REVEREND FRANK BALDWIN, Senior Pastor of the Orinda Community Church of the United Church of Christ, Orinda, California.

RABBI JONATHAN BIATCH, Rabbi of Temple Beth El in Madison, Wisconsin.

THE REVEREND JOHN R. BROOKE, United Church of Christ, President of the Americans for Death with Dignity, and clergy coordinator for the Compassion and Choices proposed legislation in California.

THE REVEREND DOCTOR KEN BROWN, District Executive of the Pacific Southwest District of the Unitarian Universalist Association, Studio City, California.

THE REVEREND PAUL CHAFFEE, United Church of Christ, Executive Director of the Interfaith Center at the Presidio in San Francisco, California.

THE RIGHT REVEREND JOHN BRYSON CHANE, Eighth Bishop of the Episcopal Diocese of Washington, D.C.; Co-Chair of the "Bishops Working for a Just Society" Coalition and of the Episcopal Church's Committee on National Affairs; and board member of the American Friends of the Episcopal Diocese of Jerusalem, the University Council Committee on Religious and Spiritual Life at Yale University, the Episcopal Church Publishing Company, the Virginia Theological Seminary and Collington Retirement Center, Saint Anna's Home, and Saint Mary's Home.

DOCTOR JOSEPH CHUMAN, Leader of the Ethical Culture Society of Bergen County and Professor of Human Rights and Religion at Columbia University.

THE REVEREND DOCTOR JOHN B. COBB, JR., United Methodist Church, Professor Emeritus of Theology at the Claremont (California) School of Theology; Co-Director of the Center for Process Studies; and Co-founder, Progressive Christians Uniting.

THE REVEREND RALPH H. COOK, Unitarian Universalist, retired professor of the Starr King School for the Ministry.

THE REVEREND DONALD FADO, retired pastor of St. Mark's United Methodist Church of Sacramento, California.

THE REVEREND DUANE H. FICKEISEN, Parish Co-Minister of the Unitarian Universalists of the Cumberland Valley in Boiling Springs, Pennsylvania; President of the Priestley Kingsbury Chapter of the Unitarian Universalist Ministers Association; and Co-President of the Unitarian Universalist Clergy Couples Association.

THE REVEREND GLEN HOLMAN, Disciples of Christ, Sacramento, California, and retired Executive Director of the California Council of Churches.

PROFESSOR JOSEPH C. HOUGH, JR., President of the Faculty and William E. Dodge Professor of Social Ethics at the Union Theological Seminary in the City of New York, and ordained minister in the United Church of Christ, Congregational.

THE REVEREND DOCTOR DAVID J. JAMIESON, Conference Minister Emeritus of the Northern California Nevada Conference of the United Church of Christ.

THE REVEREND PAUL KITTLAUS, Assistant Minister of the United Church of Christ in Claremont, California.

THE REVEREND PETER LAARMAN, Executive Director of Progressive Christians Uniting.

PROFESSOR DANIEL MAGUIRE, Professor of Moral Theology at Marquette University (a Jesuit Catholic institution of higher education).

RABBI BONNIE MARGULIS, rabbi of Reform Judaism.

THE REVEREND WILLIAM MCKINNEY, United Church of Christ, President of and Professor of American Religion at the Pacific School of Religion in Berkeley, California.

THE REVEREND DOCTOR RALPH M. MERO, JR., Unitarian Universalist, founder of Compassion in Dying and member of the national staff of the Unitarian Universalist Association in Boston, Massachusetts.

THE REVEREND AMY ZUCKER MORGENSTERN, Parish Minister of the Unitarian Universalist Church of Palo Alto, California.

THE REVEREND DOCTOR WILLIAM R. MURRY, former President of the Meadville Lombard Theological School in Chicago, Illinois, and Editor of The Journal of Liberal Religion.

THE REVEREND DOCTOR KENNETH W. PHIFER, Senior (and soon-to-be Emeritus) Minister of the First Unitarian Universalist Congregation of Ann Arbor, Michigan; member of the Human Subject Review Committee of the University of Michigan Medical School; and founder of the Interfaith Roundtable.

THE REVEREND DOCTOR GEORGE V. PIXLEY, American Baptist theologian and retired missionary and former Resident Scholar of the Institute for Ecumenical and Cultural Research.

THE REVEREND DOCTOR GEORGE F. REGAS, Rector Emeritus of the All Saints Episcopal Church in Pasadena, California.

THE REVEREND DOCTOR PATRICIA S. ROSS, Senior Minister at the First Congregational United Church of Christ in Portland, Oregon.

THE REVEREND LAROLD K. SCHULZ, retired pastor in the United Church of Christ.

THE REVEREND DOCTOR PAUL D. SIMMONS, Baptist, Director of the Center for Ethics: Ministry, Business, and Medicine, Clinical Professor of Family and Geriatric Medicine, and Adjunct Professor of Philosophy, University of Louisville and Louisville Presbyterian Seminary; Trustee of Americans United for Separation of Church and State, and

member of the Religious Consultation on Population, Reproductive Health and Ethics; the American Society of Law, Medicine and Ethics; the American Society for Bioethics and the Humanities; American Academy of Religion; and the Society for Christian Ethics.

THE RABBI SUZANNE SINGER, Rabbi of Temple Sinai, First Hebrew Congregation in Oakland, California.

THE REVEREND DOCTOR PAUL SMITH, Senior Minister of the First Presbyterian Church of Brooklyn; Vice Chairperson of the Board of Directors of the Arthur Ashe Institute for Urban Health; and member of the Board of Regents of the Long Island College Hospital.

THE RIGHT REVEREND JOHN SHELBY SPONG, retired Bishop of the Episcopal Diocese of Newark, New Jersey, and 2000 William Belden Noble Lecturer, Harvard University.

RABBI JOSHUA STAMPFER, Rabbi Emeritus of the Congregation Neveh Shalom, Portland, Oregon; Adjunct Associate Professor of Urban Studies & Planning - Urban & Public Affairs and Portland State University; and Appointee to the Oregon Government Ethics Commission.

THE REVEREND RON STIEF, Minister and Team Leader of the Washington Office of the United Church of Christ Justice and Witness Ministries.

THE REVEREND JERALD M. STINSON, Senior Minister of the First Congregational Church, United Church of Christ, in Long Beach, California.

RABBI ARIEL STONE, Rabbi of Congregation Shir Tikvah in Portland, Oregon.

THE REVEREND DEBORAH STREETER, Associate Conference Minister of the Northern California Nevada Conference of the United Church of Christ.

THE REVEREND DOCTOR DAVID THOMPSON, Senior Pastor and Head of Staff at the Westminster Presbyterian Church in Sacramento, California.

JANET K. VANDEVENDER, ESQUIRE, Chair of the Board of Directors of the Southern California Nevada Conference for the United Church of Christ.

THE REVEREND CARLTON VEAZEY, Minister of the National Baptist Convention, U.S.A., and Pastor of the Fellowship Baptist Church in Washington, D.C.

RABBI ARTHUR WASKOW, Director of The Shalom Center in Philadelphia, Pennsylvania, and author of many books on U.S. public policy and on Jewish and spiritual life.

THE REVEREND JUDY CLYMER WELLES, Parish Co-Minister of the Unitarian Universalists of the Cumberland Valley in Boiling Springs, Pennsylvania, and Vice-President of the Graduates Association of the Starr King School for the Ministry in Berkeley, California.

THE REVEREND DOCTOR RAY WELLES, retired pastor in the United Church of Christ; semi-retired church consultant; and spiritual counselor.